DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 2 4

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: CFR 42

7. FEDERAL BUDGET IMPACT:
a. FFY 01 $ 0
b. FFY 02 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B page 2
Appendix A pages 1, 2, and 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B page 2
Appendix A pages 1, 2, and 3

10. SUBJECT OF AMENDMENT: Clarifies the percentage of outpatient cost to be paid when final settlements are calculated; removes interim settlements and limits the time period DSS will reopen cost reports for final settlements.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT cc
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Dana Katherine Martin

14. TITLE: Director

15. DATE SUBMITTED: September 5, 2001

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/06/01

18. DATE APPROVED: NOV 08 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Nanette Foster Reilly

22. TITLE: Acting ARA for Medicaid & State Operations

23. REMARKS:

cc:
Martin
Vadner
Waite
CO

SPA CONTROL
Date Submitted: 09/05/01
Date Received: 09/06/01

FORM HCFA-179 (07-92)

Instructions on Back

1. Reasonable costs as determined by the state agency's annual review of the participating hospital's outpatient fiscal year-end cost reports and reconciliation of the Medicaid allowable charges and reimbursement for Medicaid services provided during that fiscal year; or

2. Usual and customary charges as billed by the provider of services and as representing a prevailing charge in the locality for comparable services under comparable circumstances.

C. All facilities which meet the Medicare criteria for exemption from the lower of cost or charge limitation as nominal charge providers for fiscal year cost determination shall have their net reimbursement determined at no more than one hundred percent (100%).

D. For reporting purposes in the outpatient Medicaid data, facilities shall not include services reimbursed from a fee schedule, which include services to GR recipients, the clinical diagnostic laboratory services as identified on page 2a of attachment 4.19-B, and services of hospital-based physicians and certified registered nurse anesthetists.

E. Medicaid outpatient cost settlements will be determined utilizing a total outpatient cost-to-charge ratio derived for each facility by treating the facility's total outpatient services (ancillary, emergency room and clinic) as one (1) single, combined department.

F. Outpatient hospital services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the deductible and coinsurance as imposed under Title XVIII.

I. Outpatient hospital settlements, Provider-Based Rural Health Clinic (PBRHC) settlements or Provider-Based Federally Qualified Health Centers (PBFQHC) settlements will be calculated after the Division receives the Medicare/Medicaid cost report with a Notice of Provider Reimbursement from the hospital Fiscal Intermediary.

A. The Division of Medical Services shall adjust the hospital's outpatient Medicaid payments, PBRHC/PBFQHC Medicaid payments (except for those hospitals that qualify under subsection I.B., whose payments will be based on the percent of cost in I.A.1., 2, 3 or 4. for:

1. Services prior to January 5, 1994, the lower of eighty percent (80%) of the outpatient share of the costs from subsection I.D., or eighty percent (80%) of the outpatient charges from paragraph I.C.1.,;

2. Services after January 4, 1994 and prior to April 1, 1998, the lower of ninety percent (90%) of the outpatient share of the cost from subsection I.D., or ninety percent (90%) of the outpatient charge from paragraph I.C.1.;

3. Settlement for services after April 1, 1998 will be calculated in accordance with subsection I.B. on page 1a of Attachment 4.19B.

4. PBRHC and PBFQH shall be reimbursed 100% of its share of the cost in subsection I.D.

B. A facility that meets the Medicare criteria of nominal charge provider for the fiscal period shall have its net cost reimbursement based on its cost in subsection I.A.1., 2 or 3.

C. The Medicaid charges used to determine the cost, and the payments used to determine the settlement will be:

1. For outpatient services the charges and payments extracted from the Medicaid outpatient claims history for reimbursable services paid on a percentage basis under Attachment 4.19B

2. For provider based PBRHC and PBFQHC the charges and payments will be services billed under Attachment 4.19B, page 8 for FQHCs and page 44 for PBRHCs.

D. The Medicaid hospital's outpatient, PBRHC or PBFQHC cost will be determined by multiplying the overall outpatient cost-to-charge ratio, determined in accordance with paragraph I.D.1., by the Medicaid charges from paragraph I.C.1. To this product will be added the Medicaid outpatient share of GME. The GME will be determined using the methodology on worksheet E-3 part IV from the Medicare/Medicaid cost report (HCFA 2552-92) by substituting Medicaid data in place of Medicare data:

1. The overall outpatient cost-to-charge ratio will be determined by multiplying the reported total outpatient charges for each ancillary cost center excluding PBRHC or PBFQHC on the supplemental worksheet C column 1 (HCFA 2552-83) or substitute schedule by the appropriate cost-to-charge ratio from worksheet C (2552-92) column 7 part I of the fiscal intermediary's audited Medicare/Medicaid cost report to determine the outpatient cost for each cost center that is reimbursed on a percentage of charge basis by Medicaid under Attachment 4.19B. Total the outpatient costs from each cost center and total the outpatient charges from each cost center. Divide the total outpatient costs by the total outpatient charges to arrive at the overall outpatient cost-to-charge ratio.

E. The Medicaid outpatient final settlements will determine either an overpayment or an underpayment for the hospital's outpatient services and PBRHC or PBFQHC:

1. The outpatient Medicaid cost determined in section I.D. is multiplied by the percent of cost allowed in paragraph I.D.1., 2., or 3., to determine the reimbursable cost for outpatient services. (If a cost report covers both periods the outpatient Medicaid charges will be split to determine the reimbursable cost for each time period.) From this cost subtract the outpatient payments made on a percentage of charge basis under Attachment 4.19B for the time period. (Medicaid payments include the actual payment by Medicaid, third party payments, coinsurance and deductibles.) The difference is either an overpayment (negative amount) due from the provider or an underpayment (positive amount) due to the provider; and

A. For PBRCH or PBFQHC services multiplying the PBRHC or PBFQHC charges from paragraph I.C.2., by the cost center's cost-to-charge ratio to determine PBRHC or PBFQHC cost. From this cost, the

PBRHC or PBFQHC payments associated with charges from paragraph I.C.2., are subtracted. The difference is either an overpayment (negative amount) due to the provider or an underpayment (positive amount) due to the provider.

II Reopened cost reports received after the Division has completed a final settlement will be calculated in the same manner as the original settlement. The Division will not reopen any cost report when the amended NPR is received more than five years after the hospital fiscal year end, unless the reopening is due to the provider submitting false or fraudulent information in its cost report. If the amended cost report changes, the previous settlement by less than one hundred dollars ($100), the cost report will not be reopened.